CENTRAL VIRGINIA TRAINING CENTER
September 9-10, 2004
OIG Report#104-04

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Central Virginia Training Center in Lynchburg, Virginia during September 9-10, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. The domains include: missions and values, access, service provision, facility operations and community relationships. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the five training center facility directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff and directors of mental retardation services for community services boards. The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. This report is divided into five primary sections focusing on each of the domains.

SOURCES OF INFORMATION: Interviews were conducted with twenty-seven (27) members of the staff including administrative, clinical and direct care staff. Documentation reviews included, but were not limited to: four (4) clinical records, approved behavioral plans, selected policies and procedures, staff training curriculums, facility quality management plans, survey materials and performance improvement initiatives.

MISSION AND VALUES:

1. The facility has a clear mission statement.

Interviews were completed with twenty-seven (27) members of the staff including administrative, clinical and direct care staff. At the time of the inspection, administrative staff indicated that the facility did not have a formally defined mission statement but identified this as a project that the new facility director wants to undertake during this fiscal year. Staff notified the OIG at a later time that an outdated facility mission statement had been discovered and would serve as the foundation for their planned review.

All of the staff members interviewed had a working knowledge of elements that would define the facility's mission. The most frequently presented elements included the following: to provide quality services to the residents, to address each resident's individual needs through person-centered planning, to provide a safe environment and to assure that services are provided by a well trained competent workforce.

2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.

Of the twenty (20) staff members asked to address this quality statement, all indicated that the facility operates from the principle of treating each individual with dignity and respect. Most (17) related that when the staff treat each other this way the value extends to the manner in which the staff treat the residents. Other values identified included honesty, integrity, professionalism and equality of treatment. Interviews revealed that the facility has an extensive staff-mentoring program. One of the goals of this program is for seasoned staff to be paired with newly hired staff so that the more experienced staff can model appropriate interactions between the staff and the residents while assisting the new staff in understanding the expectations regarding their position. The staff picnic was identified as a way of letting staff know that they are valued and that they play a valuable role in the quality of services provided.

ACCESS/ADMISSIONS

1. Policies and Procedures that govern admission are consistent with the facility's mission statement.

The OIG could not make a determination regarding this quality statement, as the facility did not present the team with a formalized mission statement at the time of the inspection.

2. Admission to the facility is based on a thorough assessment of each applicant's needs and level of functioning.

Interviews with seven (7) administrative and supervisory staff members, a review of four resident records, and a review of facility policy revealed that the facility's admission process is based on a thorough assessment of each applicant's needs and level of functioning.

A committee at the facility designed to assure that the facility is both the least restrictive alternative and the best setting for addressing a person's needs screens each potential applicant. As with the other training centers, CVTC has a well-defined admissions process. This involves a thorough review of the information forwarded by the community services board regarding the applicant's status and need for services. Interviews indicated that the community assessments conducted and submitted as a part of the admission process include, but are not limited to:

- Current medical status including immunization history and psychiatric evaluation
- Psychological assessment (less than 3 yrs old)
- Social history
- Individualized Educational Plan (IEP) for those ages 2 through 21
- Vocational evaluation (if in a community day program)
- Prescreening Report (including identification that no less restrictive alternative exists, training recommendations and discharge plans)

Once the applicant is admitted to the facility, a registered nurse (RN) reviews the referral information record and conducts an initial assessment, including identifying areas of risk such as falls. The resident receives a full physical within 24 hours of admission. Other disciplines such as psychology, social work, occupational therapy and physical therapy complete individualized assessments of the resident in preparation for completing the resident's individualized habilitation plan (IHP). The expectation is that the IHP be completed within thirty days of the admission. Throughout this process, observations are made of the resident's adjustment to the facility. In addition, communication is maintained with the resident's legally authorized representative during this initial period as well to keep them informed of the resident's progress. Through the use of observation and communication with the resident, the facility assures that the goals and objectives that are developed are based on the resident's preferences and needs.

There have been two (2) planned admissions to the facility during the period of 7/1/03 to 7/1/04.

3. The facility has a mechanism in place for addressing emergency admissions.

Interviews revealed that emergency admissions are handled in the same manner as those seeking regular admissions. It was reported that the facility receives between three to five requests each month for emergency admission but less result in a formal application for admission. When there is a request for an emergency admission, the facility first reviews possible ways of aiding the person through the development of additional supports so that he/she will be able to remain in the community. Facility staff are available to provide the consultation necessary to support this goal. Interviews revealed that this intervention has been successful in reducing the number of emergency admissions. After completing the necessary assessments, if it is determined that emergency admission is the best alternative for the person, it is the goal of the facility to facilitate discharge back into the community as soon as possible with twenty-one (21) days being the targeted timeframe. After this time period, the facility, in conjunction with the community services board, reviews whether the person needs longer-term care or regular admission. The facility reported that during the last fiscal year there had been twelve requests for emergency admissions of which six resulted in admission.

SERVICE PROVISION / CONSUMER ACTIVITIES

1. Activities are designed to facilitate socialization, skills acquisition and community integration.

Four resident records were reviewed. All provided evidence that the individualized habilitation plans were designed to address skills acquisition, facilitate socialization and provide opportunities for community integration.

Training programs with residents from Rapidan Park and Bannister were observed. Four staff members were interviewed. They demonstrated knowledge of each resident's goals and objectives. There was a wide range of activities including story telling, crafts, music,

and movement. Staff were engaged with each resident and were observed treating them with dignity and respect. Staff were noted to address the resident and ask for permission to share their goals with the inspection team. Staff made a point of introducing the residents and including them in the conversation.

The team observed two residents involved in physical therapy. The therapist worked with one individual while a physical therapy aide was assisting the other resident. The residents appeared happy. There was a relaxed, easy interaction between the residents and the staff.

2. Residents are actively engaged.

Observations in a variety of programming settings revealed that the residents are actively engaged. For example, the team observed one group participating in a craft activity. Staff explained that even though there was a defined activity occurring, the goal of the group varied for each resident. Some were working on developing their fine motor skills, others on increased attention span. The goal for one resident was to remain engaged in the activity for a defined period of time. Staff were supporting each resident in addressing his/her goal(s) throughout the activity.

3. Activities occur as scheduled.

Interviews and observations revealed that the activities were occurring as scheduled. Activities for a majority of the residents were occurring on their living units instead of at the normal day program setting because there was a severe storm warning in effect. Staff explained that it was decided to have the residents remain on the units because of the potential risks associated with the warning.

Several units were scheduled for an overnight outing at the campground on campus. It was indicated that because this is an activity enjoyed by both the residents and staff, the unit intended to proceed with the outing. Staff reported that every effort would be made to complete the scheduled campground activities but that this was contingent upon the weather.

4. Residents are supported in participating in off-grounds activities.

Interviews with staff revealed that the residents have opportunities to participate in individual and small group activities in the community such as going shopping, going to the local parks, to the zoo, movies and other recreational activities.

5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.

Interviews with four members of the administrative and clinical staff indicated that discharge planning is viewed as an integral part of the overall habilitation plan for each resident. There are 15 social workers at the facility that serve as the community liaison

with the resident's legally authorized representative and community case manager. The team was informed that there were 75 residents identified for discharge. Active planning on their behalf includes having potential community providers visit the campus. This provides opportunities for both the provider and resident to interact with each other before visits into the community are arranged. Facility staff are available to assist the resident and community staff by providing transition services. Interviews revealed that the facility has a 90-day timeframe for residents to return to the facility if problems arise during the initial phases of the placement instead of the traditional 28-day timeframe. The team was informed that outreach services were less available due to limited resources.

FACILITY OPERATIONS / SAFE ENVIRONMENT

1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.

Interviews revealed that the safety and security of the residents is one of the highest priorities established by this facility. This was voiced by all those interviewed from the facility director to the direct care staff. The facility has developed a number of ways for assessing and monitoring the safety and security of the residential units.

Interviews indicated that safety begins with the proper identification of all persons on campus. Each visitor is asked to sign in and is given an identification badge. Staff are trained to provide a "watchful" eye not just for unidentified persons on campus but to recognize and report any areas of potential hazard or risk. The facility has a Safety Committee that reviews all aspects of campus safety. Safety audits of the buildings are conducted at least monthly. Work orders can be forwarded to Buildings and Grounds from any department on campus. The work completed is prioritized based on its level of risk.

The Environment of Care Committee reviews areas identified with specific risks, such as falls and medication errors. Once an issue is identified, the committee develops a plan of correction and tracks the plan until it has been resolved.

The facility maintains a police force of eight, including a Chief of Police and seven certified law enforcement officers. The officers patrol the campus and conduct security checks on the buildings. The campus police have direct contact with the local fire and emergency response units. They are responsible for the grounds and a one-mile perimeter around the campus. This also includes a 12-mile jogging path that runs beside the campus. The Chief of Police works to maintain a good working relationship with both the Lynchburg and Amherst County law enforcement offices.

2. There are adequate safeguards to protect residents from abuse and neglect.

Interviews revealed that the safeguards for protecting the residents from abuse and neglect start at the hiring process. Background checks are conducted on all new hires. Staff training regarding human rights, abuse and neglect is included in staff orientation

for new hires and again in annual trainings. The trainings review the definitions of abuse and neglect as well as the procedures for staff reporting allegations of such.

The human rights advocate participates in a number of forums during which issues associated with the residents are discussed. One of these forums is the morning report. This is a meeting during which significant events of the previous 24-hours are reviewed and discussed, including resident injuries. In addition, the advocate reviews all allegations of abuse and neglect, and monitors the investigation process on behalf of the consumer. Allegations are reported to the facility director who forwards the allegations to the investigator for review and follow-up as appropriate. Two members of the facility's police force are primarily assigned as investigators of abuse and neglect. It was noted that these individuals do a very nice job balancing their duties within the facility and completing the investigation in a timely manner. There were 20 allegations of abuse and neglect at the facility during the first six months of 2004. Four were substantiated.

One key safeguard emphasized by those interviewed was the length of time a majority of the staff has been employed at the facility. Interviews revealed that it is not unusual to have a number of staff members in the residential units that have "grown up" with the residents over the past 15 to 25 years. Staff were described as dedicated to the residents, which was noted as a major factor in the prevention of abuse and neglect.

3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.

The risk manager tracks critical incidents, both those that fit the criteria for reporting to VOPA and those incidents that impact patient safety but do not result in injuries such as the number of falls and peer to peer aggression. The facility risk manager also reviews critical incidents for elements of possible abuse and neglect. Data is collected and routinely communicated with management and staff. There have been approximately 170 reported incidents at this facility from January – June 2004. There were 224 incidents of peer-to-peer aggression during this same period, 158 of these incidents resulted in injuries to one or both of the residents involved. Performance improvement teams have been designed to address issues identified through their review. Routine safety and security checks are a mechanism for identifying and addressing environmental issues that could jeopardize the well being of the residents.

The facility has a hospital on-site to provide for first line response to emergencies. There is a physician on the campus at all times. Physicians and RNs are required to maintain advanced life saving certification.

4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.

CVTC has not used locked or isolated time-out since the early 1980's. Protective restraints are used by the facility. Protective restraints refer to devices used to compensate for a "specific physical deficit" and are considered a restraint only when the resident does

not have the option to remove it, such as a helmet that acts as a passive barrier but can not be removed by the resident. The voluntary use of a helmet designed to protect the resident is not considered a restraint, according to those interviewed. The use of protective restraints and mechanical supports are outlined by policy. Members of the rehabilitation staff meet with the resident to conduct an evaluation and to make recommendations to the team regarding the use of protective restraints and mechanical supports. The evaluation identifies the specific needs that will be addressed by its use. A physician's order is necessary before use of the restraints can be initiated.

During the tour of Shenandoah House, staff shared that there is a chair that was used to restrain residents when their behavior presents imminent risk to themselves or others. The team was informed that use of the chair is a part of a particular resident's behavior management plan. Several staff, however, stated that the chair is used with residents without plans if the frequency of use is below an established threshold for initiating a formalized behavioral plan.

At the time of the inspection, the team was informed that the facility had 215 residents in approved protective restraints. These included the use of seatbelts, helmets, bedrails, adaptive clothing and tray boards. There were 350 residents with behavioral plans, 215 of which are classified as restrictive.

5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.

Human Rights training is provided for all staff at the time of their orientation and annually thereafter. Residents and their legally authorized representatives are advised of the human rights process at the time of admission and at least annually. Documentation of this is located in the resident's record.

The facility has both an informal and formal process for handling complaints. The facility director handles informal complaints, as is the procedure with the other training centers. It was noted that the facility handled 12 informal complaints and addressed 8 formal complaints during the first six months of 2004.

6. Medication usage is appropriately managed.

The facility has established policies and procedures for the handling of medications. Staff are appropriately trained in the use of medication management and must demonstrate competency before being able to administer them. Monitoring medication usage is completed by the pharmacy. Areas reviewed include medication errors, accountability for controlled drugs and adverse drug reactions.

Interviews revealed that the facility has placed a great deal of emphasis on the reporting of medication errors. The focus is primarily on the correction of errors and not just on disciplining the staff. Interviews indicated that as the facility has stressed learning over

discipline whenever possible, the reporting of errors has become timelier so that they can be appropriately handled.

7. There are mechanisms to address areas of concern regarding staff safety.

There is an expectation at the facility that staff injuries are to be reported in a timely manner. The human resources office tracks these and claims are filed, as appropriate.

The Safety Committee and Office of Risk Management address issues identified as staff safety risks. Environmental safety checks identify and correct physical conditions that could have an impact on the safety of both the staff and residents. Members of the campus police force provide for the public safety of all persons on the campus and have been utilized when issues of domestic violence or other difficulties are brought to the work setting.

FACILITY OPERATIONS / LIVING ENVIRONMENT

1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.

Many of the residential units that were toured appear very institutional in spite of efforts to make the environment appear more homelike. Decorations were used to "soften" the overall stark appearance in all the residential areas. The use of pictures and other forms of decorations was primarily in the common areas. The resident bedrooms were less decorated. It was noted that the living areas in Shenandoah House were freshly painted. Curtains and other coverings are used to assure resident's privacy in all of the areas toured.

2. The residential environment is clean, odor free and well maintained.

Members of the OIG team conducted tours of selected units in Shenandoah Hall, Rapidan Park, and Bannister Hall. The facility was noted to be extremely clean, well maintained and odor-free.

Interviews revealed that the three most critical capital improvement projects for this facility are renovations to Building 8, Building 9 and Building 12 which involved complete renovations to meet Life / Safety Code standards including removing the pony walls and providing full height walls; installing a sprinkler system, fire alarm and smoke detection systems; and renovating the HVAC system. The capital improvement project for Building 8 was funded in the 2004-2006 biennium budget at $3 million. The renovations for Building 9 and 12 are not funded but the team was informed that funding would be requested during the 2006-2008 and 2008-2010 biennium, respectively. The projected costs for these renovations total $7 million.

There are several capital improvement projects that are currently approved and funded. These include:

- Repairing and replacing the roofs on Building 49 and Building 31 at a cost of $708, 217.
- An asbestos abatement project, which includes removing asbestos from pipes in the pipe chases and mechanical rooms, and removing floor tiles and reinsulating/retiling in selected buildings
- Building 11 renovations

The first two projects listed are currently near completion. The renovations on Building 11 are funded but bids have not been completed.

3. There is evidence that the residents are being taken care of by the facility.

Throughout the tours, the team had an opportunity to observe the residents. All appeared properly clothed, clean and well provided for by the facility. It was observed that staff promptly addressed any hygiene problems with the residents as they arose. The staff were supportive of the residents and were observed treating them with dignity and respect. One team member rode a bus that was transporting residents from their residential units to the day treatment activities. Staff and resident interactions were relaxed, jovial and respectful.

4. The facility provides for access to primary health care that is coordinated and comprehensive.

On the day of the inspection, there were 573 residents. CVTC has five (5) service centers on campus. Four (4) of the centers are certified intermediate care facilities for persons with mental retardation (ICF/MR) and one (1) center is a skilled nursing unit. In addition, the facility has an acute care center on grounds. The facility has ten (10) primary care physicians including one full-time psychiatrist. There is also one family nurse practitioner on staff. Medical care staff are assigned to the units and complete daily rounds. There is a physician on the campus at all times. After 5:00 p.m., the physician is based in the clinic.

All residents receive a comprehensive annual physical. In addition, residents have access to a number of clinic services. The facility uses Lynchburg General Hospital or the University of Virginia Hospital for special hospitalization and emergency services.

Nursing completes quarterly healthcare reviews on all of the residents, noting any changes in their healthcare status and other information regarding their physical health. The nurses have a caseload of approximately 30 residents. Two staff persons are certified emergency medical technicians.

5. The facility has a mechanism for accountability of resident's money.

There is a patient accounts division under the facility's fiscal office. Interviews with staff indicated that it is the qualified mental retardation professional (QMRP) that has the final responsibility for keeping track of the resident's funds. Requests for needed items are submitted to the QMRP who authorizes the transactions. Staff that assist the residents in making the necessary purchases are required to submit a receipt.

FACILITY OPERATIONS / STAFFING PATTERNS

1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.

Interviews with management indicated that the facility employs sufficient qualified staff to address the supervision and treatment needs of the residents. Facility management is currently reviewing how the facility is deploying its direct care staff to determine whether its current staffing patterns are the most effective use of the available personnel. The facility employs approximately 1,500 personnel of which 798 are direct care workers, nursing staff and special activities aides. The team was informed that each center is responsible for deploying staff within its units. Staff may be asked to work in any area in their assigned center depending on need such as when residents are on a 1:1 status or there are staff absent due to illness or vacations. The direct care staff reported that there was adequate staffing but maintained that the numbers required for addressing the needs of the residents are secured through an extensive use of overtime.

Four units in the Shenandoah House were toured. One unit housed 7 residents and had 4 staff persons. The remaining units had up to 12 residents and 5 staff members present. The team visited two units in Bannister. Both units had 12 residents and 3 staff members present.

2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of resident supports and care.

Interviews indicated that the turnover rate for the facility is relatively low. The rate is the second lowest of all of the state training centers. The team was informed that the average number of years of service for the employees is fifteen (15) years. Many of those interviewed during this inspection reported being employed by the facility for 25 to 30 years.

Overtime usage at the facility is extensive due primarily to the number of call-ins, the acuity level of the residents and an increase in the use of 1:1. Overtime is one factor that is being examined as management reviews the effective deployment of staff. Interviews with direct care staff cited overtime as the primary source of work frustration and dissatisfaction.

3. Direct care staff possesses the competencies necessary for providing services.

Interviews with training and supervisory staff, as well as a review of the training materials revealed that the majority of critical tasks for direct care staff are based on competency reviews, which involved either tests or demonstrations. Interviews revealed that as most of the supervisory staff tend to be long-term employees and are well-versed in the issues that the direct care staff are facing.

FACILITY OPERATIONS / SYSTEM PERFORMANCE

1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.

Data collection is used to support and enhance facility performance in a number of areas. Staff training data is maintained and reported to the facility risk manager on a monthly basis to assure that all staff are compliant with the required training. Performance evaluations are tracked for additional training needs.

The Office of Information Technology (IT) has been effectively used to assist the occupational therapists and speech therapists in using digital pictures for demonstrating the proper positioning and adaptive equipment used for the nutritional management of the residents.

It was indicated that the administration is very supportive of enhancing the facility's ability to upgrade its systems in order to provide additional support of the various services and programs. However, with limited resources, the administration is often forced to choose between additional computers and replacing a broken dishwasher. Those interviewed related that it is understandable that the facility will prioritize funding that which has the greatest impact on the residents.

2. There is a system for continuous quality improvement.

Interviews revealed that the facility has initiated a number of successful quality improvement projects designed to enhance the quality of services for the residents. One such example is a performance improvement project that assures that the food served each resident is of the consistency needed, served at an appropriate temperature and appropriate to his or her nutritional needs. Interviews revealed that the new facility director has, in cooperation with senior management, developed a process for increasing quality assurance initiatives within the facility.

3. Residents and other stakeholders have an active role in program development and quality improvement activities.

Interviews revealed that families have not been formally involved in program development and quality improvement activities within the facility but indicated that a

number of families have actively advocated for the residents. They have worked with the facility in crafting programs designed to meet the needs of all of the residents.

COMMUNITY RELATIONSHIPS

1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in its catchment area.

One of the goals established by the new facility director is to understand and strengthen wherever possible the working relationships that the facility has with agencies within the community. The facility has initiated the establishment of regular and ongoing meetings with the primary community services boards served by CVTC. Most of the work to-date occurs in the context of interactions resulting from services provided to the residents through admissions, discharges and outreach.

2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:

a. With Community Services Boards

Even though no formalized surveys have been conducted with the community services boards, the facility has initiated the establishment of regular and ongoing meetings.

b. With parents and/or legally authorized representatives

The facility conducted a satisfaction survey with parents and/or legal guardians three years ago. It was reported that the DMHMRSAS Central Office conducted a survey last year but interviews indicated that the facility was not provided with feedback on the results. Those interviewed indicated that the facility values the comments of family and believes it is vital to the organization to keep the residents, families and other stakeholders involved and informed.

c. With the DMHMRSAS Central Office

Although interviews indicated that there was not a formal mechanism established with Central Office management for obtaining feedback regarding the facility's performance, staff outlined several ways in which the facility is able to interface with the Central Office. These include the facility directors meetings, the medical directors meetings, and on-going contact with the DMHMRSAS IT Department and the Office of Risk Management. The facility director indicated that Central Office staff have actively provided support to assist her in becoming more familiar with the workings of the mental retardation service delivery system.

Interviews revealed that a recent unannounced visit by Secretary Woods to the facility was very welcomed because it highlighted for facility personnel that she valued the role the facility serves in the delivery of services to persons with mental retardation.

3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.

Because a number of the staff interviewed have been employed by the facility for an extended period of time, they provided a longitudinal perspective on the capacity of the community to provide services to persons traditionally served by the facility. Most indicated that over the past ten to fifteen years there has been a concerted effort by both the facility and the community to identify and facilitate residents having the opportunity to reside in the least restrictive setting possible. Although the majority of staff interviewed indicated a belief that all residents could reside in the community with the proper supports, it was still felt that the facility was currently the best-equipped provider of care for individuals with challenging maladaptive behaviors and complicated medical conditions.

Fourteen staff members were asked about the facility's role. All indicated a belief that the facility has a unique role to play in the delivery of services, particularly since CVTC is the only training center that offers intermediate, skilled and acute services. Interviews indicated that the staff have a wealth of expertise that could be a valuable resources for the community in order to maximize success for all consumers.

Seven of the staff interviewed indicated that with the arrival of a new director the facility has an opportunity to take a fresh look at itself and re-examine its mission. They felt this was a good opportunity for staff to be able to examine both the value the facility has in serving its residents and in addressing the needs of the community as well.

4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.

It was indicated that the facility did not have any requests for respite services during the period of July 1, 2003 through July 1, 2004. CVTC has residents under the age of 18 but these individuals are housed in the skilled care unit, which is certified by Medicare.

FINDINGS AND RECOMMENDATIONS

Finding 1: The majority of staff interviewed indicated that the facility did not have a formalized mission statement.

Recommendation: It is recommended that CVTC develops a mission statement with broad-based staff participation and assure that the mission statement is consistent with the system-wide DMHMRSAS Vision Statement.

Finding 2: A majority of the residents at CVTC have been diagnosed with mental retardation, unspecified.

Recommendation: It is recommended that the facility review the current diagnosis of its residents to determine if a level of functioning and severity of mental retardation can be determined.